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AUTHOR Salzman, Kenneth P.; Salzman, Stephanie A.
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ABSTRACT

This study examined factors that may place adolescents at risk for psychological dysfunction and school failure. Subjects were 70 adolescents who were admitted to a psychiatric hospital from September 1986 to March 1988. Demographic, academic performance, familial, and psychological data were retroactively gathered from patient files, tabulated and descriptively analyzed. The results identified a number of familial, academic, social, and psychological stressors which combined to place the adolescent at risk for psychological dysfunction and school failure. The effect of multiple stressors was evidenced by the high degree of suicidality of subjects; more than one-third had attempted suicide at least once and required hospitalization for either suicidal ideation or a suicide attempt. Many of the same adolescents experienced accompanying family dissolution, school failure, and had histories of drug use and physical and/or sexual abuse. Despite the variety of stressors identified, one dimension emerged as an identifiable risk factor; 48 subjects were diagnosed as having some degree of depression, a disorder with specific signs and symptoms which are readily detectable. The findings suggest that responsiveness to high risk adolescents can be facilitated through inservice training for school personnel, peer counseling programs, school-based group counseling, school-community agency collaboration, and community youth services teams. (NB)

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Characteristics of Adolescents at Risk for Psychological Dysfunction and School Failure

Kenneth P. Salzman

and

Stephanie A. Salzman

Idaho State University

CG 021711

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Characteristics of Adolescents at Risk for Psychological Dysfunction and School Failure

Adolescence can be a time of considerable stress and tension. Environmental demands, as well as the changes brought on by rapid physical development, contribute to the turmoil experienced by many adolescents. Common environmental stressors include academic pressures, conflicting family and/or peer relationships, loneliness, and pressure to make career or college choices. These stressors are exerted simultaneously with the adolescent's evolving personal, social, and physical identities.

In light of the number of stressors during adolescence, it is not surprising that many teens have difficulty coping with their everyday lives. The scope and severity of the problem are evidenced by the increasing number of adolescents seeking psychological counseling. The proportion of children between the ages of 12 and 17 referred to psychological counseling or therapy has nearly doubled since 1960 (Select Committee on Children, Youth, and Families, 1987). The magnitude of the problem is brought into even greater focus by recent evidence showing increased incidence of teen suicide and substance abuse. Suicide among adolescents has nearly tripled over the last 30 years (Klagsbraun, 1984) and two-thirds of all high school seniors report drinking alcohol, a quarter report using marijuana, and 1 in 15 report using cocaine (Select Committee on Children, Youth, and Families, 1987).

With the probability that the environmental pressures of

adolescence will increase rather than decrease in the immediate future, teachers and parents must educate themselves and others to recognize the antecedents of adolescent dysfunction. While there have been numerous studies investigating the etiology and warning signs of adolescent problems, most research has consisted of correlational studies or the study of single factors. For example, there has been much attention devoted to "broken homes" as a factor in adolescent drug abuse, suicide, and school dropout (Atkinson & Ogston, 1974; Goldstein, 1983; Walker, 1980). Other factors studied include parental alcoholism (Hudgens, 1974) and physical and sexual abuse by parents (Deykin, Alpert, & McNamara, 1985; Green, 1978).

However, the common denominator in the lives of troubled adolescents is not to be found in a single factor or event. A number of familial, academic, social, and psychological stressors combine to place the adolescent at risk. To date, there has not been adequate investigation of the interrelationships between these stressors and the manner in which they individually and collectively signal adolescent dysfunction.

Purpose of Study

The purpose of the present study was to examine the constellation of factors that may place adolescents at risk for psychological dysfunction and school failure. The study also sought to identify ways the sequence of factors could be interrupted by parents and educators who recognize danger signals.

Method

Sample

The study sample included 70 adolescents aged 12 through 18 (mean age = 15 years, SD = 1.8 years) admitted to a psychiatric hospital in a metropolitan area of southeastern Idaho from September 1986 to March 1988. Of the 34 boys in the sample, one was American Indian, two were Hispanic, and the rest were caucasion. Of the 36 girls, one was Indian, one was Hispanic, and the remaining were caucasion.

Procedures

Demographic, academic performance, familial, and psychological data were retroactively gathered from patient files and coded to maintain confidentiality. A facsimile of the coding sheet appears in the Appendix. Demographic variables of the study included patient age and gender. Familial variables included child custody arrangement (i.e., natural father only, natural mother only, both natural parents, natural parent and stepparent, relative, foster or adopted) and incidence of parental substance abuse.

Academic performance was determined by scores on the Wide Range Achievement Test (reading, spelling, and mathematics subtests) and teacher/parent ratings of school achievement. Psychological variables of the study included the following seven factors: (1) psychiatric diagnosis at time of admission as categorized according to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980 & 1987); (2) source of

treatment referral (i.e., self, family, school, community agency, other); (3) existence of suicidal ideation; (4) number of suicide attempts; (5) incidence of drug/alcohol abuse; (6) number of previous psychiatric hospital admits; and (7) reported physical and/or sexual abuse.

Results

All data pertaining to the demographic, familial, academic performance, and psychological variables of the study were tabulated and descriptively analyzed. Characteristics of the study sample relative to all variables are presented in Table 1. Analysis of familial data revealed that only 26 of the 70 study subjects resided with both natural parents. For the remaining adolescents, 3 lived with the natural father only, 13 with the natural mother only, 20 with a natural parent and stepparent, 2 with a relative, and 6 were living in foster homes or adopted. Analysis of data regarding familial variables also showed that approximately one-third of the subjects reported parental substance abuse.

In terms of academic performance variables, 43 of the 70 study subjects received failing or poor school performance ratings, 19 received average school performance ratings, and 7 received ratings of good or excellent. Mean percentile rank Wide Range Achievement Test scores for the adolescents on reading, spelling, and mathematics subtests were 55.20, 48.48, and 36.12, respectively.

Analysis of data pertaining to psychological variables revealed that the most prevalent psychiatric diagnosis at time of hospital

Table 1

Sample Frequencies by Selected Variables

Variable	*n*	%
Familial		
Custody arrangement		
Natural father only	3	4.3
Natural mother only	13	18.6
Both natural parents	26	37.1
Natural parent and stepparent	20	28.6
Relative	2	2.9
Foster/adopted	6	8.6
Parental substance abuse		
Yes	29	41.4
No	41	58.6
Not known	1	1.4
Academic Performance		
Teacher/parent ratings		
Failing	13	18.6
Poor	30	42.9
Average	19	27.1
Good	5	7.1
Excellent	2	2.9
WRAT Reading (%ile rank)		
0-20	3	4.3
21-40	15	21.4
41-60	9	12.9
61-80	10	14.3
81-100	11	15.7
Not available	22	31.4
WRAT Spelling (%ile rank)		
0-20	10	14.3
21-40	10	14.3
41-60	8	11.4
61-80	12	17.1
81-100	8	11.4
Not available	22	31.4
WRAT Arithmetic		
0-20	15	21.4
21-40	13	18.6
41-60	8	11.4
61-80	9	12.9
81-100	3	4.3
Not available	22	31.4

Table 1 (continued)

Sample Frequencies by Selected Variables

Variable	*n*	%
Psychological		
Diagnosis (primary + secondary)		
Depression	48	68.6
Conduct/adjustment disorder	38	54.3
Attention deficit disorder	5	7.1
Drug abuse	7	1.0
Anxiety disorder	24	34.3
Other	7	1.0
Source of referral		
Self	10	14.3
Family	40	57.1
Community agency	20	28.6
School	0	0.0
Suicidal ideation		
Yes	47	67.1
No	25	35.7
Previous suicide attempts		
0	41	58.6
1	23	32.9
2	4	5.7
3	2	2.9
Drug/alcohol abuse		
Yes	36	51.4
No	34	48.6
Previous admits		
0	51	72.6
1	13	18.6
2	5	7.1
3	1	1.4
Physical/sexual abuse		
Yes	34	48.6
No	35	50.0
Not known	1	1.4

admission was depression (diagnosed in 48 of the 70 study subjects). Often accompanying the diagnosis of depression was the second most prevalent diagnostic category of conduct disorder/adjustment reaction (diagnosed in 38 of the 70 study subjects). Twenty-four of the study subjects were diagnosed as anxiety disordered at the time of hospital admission, while 7 were diagnosed as substance abusers and 5 as attention deficit disordered. Of the 70 study subjects, 40 were referred for psychiatric treatment by family members, 10 were self-referred, 20 were community agency referrals, while no referrals were made by school personnel. Forty-five of the 70 adolescents reported suicidal ideation and 29 reported previous suicide attempts. Of the 70 adolescents in the study, over half had histories of drug abuse and half had histories of physical and/or sexual abuse.

Discussion

The results of the present study clearly show that a number of familial, academic, social, and psychological stressors combine to place the adolescent at risk for psychological dysfunction and school failure. The effect of multiple stressors was most dramatically evidenced by the high degree of suicidality of the study subjects with more than a third of the adolescents having attempted suicide at least once in the past and requiring hospitalization for either acute suicidal ideation or a suicide attempt during the duration of the study. Many of the same adolescents experienced accompanying family dissolution, school

failure, and had histories of drug use and physical and/or sexual abuse.

The study findings also suggest that dysfunction resulting from one stressor can precipitate further dysfunction. For example, parental drug abuse can lead to a child's substance abuse, thus creating more stress for the adolescent in the community. Typically, this dysfunction leads to academic difficulties both chronically and acutely as evidenced by the substandard WRAT scores for the study sample as well as diminished school performance. Thus, environmental stressors including parental divorce and physical and sexual abuse in combination with personal acts such as attempted suicide and drug abuse are not only evidence of family or individual dysfunction, but also precipitating events that place adolescents at risk for further dysfunction and failure.

Despite the variety and recursiveness of the stressors identified in the present study, one dimension did emerge as an identifiable risk factor. Forty-eight of the 70 adolescents were diagnosed at hospital admittance as having some degree of depression, a disorder with specific signs and symptoms which are readily detectable.

Adolescent Depression

A number of studies with both hospital and outpatient populations have identified signs and symptoms of adolescent depression (Kandell & Davis, 1982; Shaffer, Whitaker, & Davies, 1987; Weisman & Klenman, 1977). A major symptom of depression is a pervasive sense of sadness often accompanied by fluctuations between indifference or apathy on

the one hand and talkativeness on the other. Many depressed adolescents display anger or rage and high sensitivity to criticism. Other factors that are characteristic of adolescent depression include poor self-esteem and feelings of helplessness, isolation, and decreased peer support. Another characteristic of adolescent depression is pessimism about the future often accompanied by death wishes or suicidal ideation. Finally, many depressed adolescents display physiological symptoms such as sleep disturbance, restlessness and agitation, increased or decreased appetite, weight gain or loss, and somatic symptoms including headaches, stomach aches, and fatique.

Any one of these signs of depression viewed individually do not necessarily signal that an adolescent is, in fact, depressed. Rather, the consistent occurrence of a constellation of symptoms coupled with abrupt changes in behavior may suggest that a teen is depressed and possibly suicidal. Presence of the symptoms of depression, in turn, place the adolescent at risk for further psychological dysfunction and school failure.

Many adolescents, however, may cover the recognizable symptoms of depression making it difficult to secure appropriate diagnoses and intervention. Teens may display "masked" signs of depression such as defiance and rebelliousness, truancy, running away, sexual promiscuity, and drug or alcohol abuse. Adolescents disguising their depression may also engage in reckless and accident-prone behavior and act with anger and frustration. These masked signs

of depression are often viewed by others as antisocial or delinquent and precipitate censure rather than understanding and assistance. It is imperative, therefore, that adults who are in contact with youth recognize the symptoms of depression and make appropriate referrals for intervention.

Intervention Strategies

In the present study no direct referrals for treatment were made by school personnel. Furthermore, school personnel did not make any indirect referrals (i.e., signs of risk noted by educators and then communicated to parents who, in turn, initiate referral for treatment). In all cases, referrals came from self, family, or community agencies following a crisis event such as family fights, running away, attempted suicide, or arrest. These findings reveal that educators are not taking an active role in identifying teens at risk.

The finding that none of the 70 adolescents in the present study were referred by school personnel suggests the need for educators to increase their awareness and understanding of the factors that place adolescents at risk for psychological dysfunction and school failure. Responsiveness to adolescents at risk can be facilitated through the following school-community collaborative interventions.

1. Inservice training for school personnel. Such training should emphasize the recognition of the symptoms of depression and ways of accessing necessary mental health services, reporting child abuse, and involving parents.

2. Peer counseling programs aimed at teens helping fellow teens. Adolescents often find it easier to talk with peers than adults. Peer counselors can be chosen by their classmates and then trained in basic counseling techniques, the recognition of the symptoms of depression or substance abuse, and how to refer for supportive services and/or treatment.

3. School-based group counseling. In school districts with adequate staffing and time, students whose backgrounds suggest high risk and those identified as experiencing dysfunction can be offered opportunities to participate in support or treatment groups. Student group counseling should be both preventive and treatment oriented.

4. School-community agency collaboration. Mental health consultation can be a useful adjunct in providing psychological services to school districts. Districts with little or no mental health services can contract with private practitioners or community health programs for training or consultation.

5. Community youth services teams. Youth services teams consisting of school representatives and a variety of community youth services specialists can identify at-risk adolescents and plan intervention. Such community-wide cooperation greatly enhances the ability of school personnel and allied professionals to monitor and treat troubled teens.

Conclusions

The present study suggests that school failure and psychological dysfunction are related to a number of environmental and personal

stressors. The finding that approximately half of the adolescents studied had made at least one suicide attempt and nearly two-thirds had seriously thought about suicide underscores the gravity of the problem and the need to identify teens at risk. Furthermore, 68.6% of the adolescents studied were diagnosed as having some degree of depression, a disorder with specific signs and symptoms which are readily detectable.

One characteristic of social development during adolescence is decreased contact with parents antecedent to emancipation. Contemporary societal trends such as breakdown of the nuclear family and full-time employment of both parents outside the home exacerbate decreased contact between parent and teen. Given these circumstances, educators are in a unique position to maintain regular contact with adolescents. It is imperative, therefore, that school personnel recognize the precursors of adolescent dysfunction rather than reacting to dysfunctional behaviors and their consequences.

References

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders. 3rd Edition. Washington, DC: APA.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders. 3rd Edition--Revised. Washington, DC.

Atkinson, B., & Ogston, D. (1974). Effect of father absence on male children in home and school. Journal of School Psychology, 12, 213-221.

Deykin, E., Alpert, J., & McNamara, J. (1985). A pilot study of the effect of exposure to child abuse on adolescent behavior. American Journal of Psychiatry, 142, 1299-1303.

Goldstein, H. (1983). Fathers' absence and cognitive development of children over a 3- to 5-year period. Psychological Reports, 52, 971-976.

Green, A. (1978). Self-destructive behavior in battered children. American Journal of Psychiatry, 135, 579-582.

Hudgens, R. (1974). Psychiatric disorders in adolescents. Baltimore: Williams & Wilkins.

Kandell, D., & Davis, M. (1982). Epidemiology of depressive mood in adolescents. Archives of General Psychiatry, 39, 1205-1212.

Klagsbraun, F. (1984). Too young to die: Youth and suicide. New York: Simon & Schuster.

Select Committee on Children, Youth, and Families. (1987). U.S. children and their families: Current conditions and recent trends. Washington, DC: United States Government Printing Office.

Shaffer, D., Whitaker, A., & Davies, M. (1987). Self-reported depressive symptoms in a non-referred adolescent population. In M. Rutter, M. Izard, & P. Read (Eds.), Depression in young people. New York: Guilford Press.

Walker, W. (1980). Intentional self-injury in school-age children. Journal of Adolescence, 3, 217-288.

Weisman, M., & Klerman, G. (1977). Sex differences and the epidemiology of depression. Archives of General Psychiatry, 34, 98-111.

Appendix

Adolescent Psychiatric Admittances:

CODING SHEET

ID # _____

Age_____

Sex _____

1. Male
2. Female

Diagnosis _____

Caretaker _____

1. Father only
2. Mother only
3. Both
4. Parent + stepparent
5. Relative
6. Foster/adopted
7. None

Referred by _____

1. Self
2. Family
3. Community agency
4. School
5. Other

Suicidal ideation _____

1. Yes
2. No

Previous attempts _____

Drug Use _____

1. Yes
2. No

Previous admits _____

Physical/sexual abuse _____

1. Yes
2. No
3. Not known

Parental substance abuse _____

1. Yes
2. No
3. Not known

WRAT Spelling _____

WRAT Reading _____

WRAT Arithmetic _____

School Performance _____

1. Failing
2. Poor
3. Average
4. Good
5. Excellent

Precipitating Event _____

_____

Comments _____

_____

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